

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **3144**
442

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 36 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 5378a Wells		0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp.				d. STREET ADDRESS (If rural, give location) St. Louis			
3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH H		b. (Middle)		c. (Last) Weitzman		4. DATE OF DEATH (Month) (Day) (Year) Jan. 14 1950	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married Wid.		8. DATE OF BIRTH unk	
9. AGE (In years last birthday) ab 62		10. IF UNDER 1 YEAR Months Days		10. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garment worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unk		13b. MOTHER'S MAIDEN NAME Unk.		14. NAME OF HUSBAND OR WIFE Bessie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) O.		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ben Weitzman 5891 Omaine			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarct (coronary throm) ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary artery atherosclerosis - arteriosclerosis heart dis DUE TO (c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. auricular fibrillation, Thyrotoxicosis (thyroidectomy)				INTERVAL BETWEEN ONSET AND DEATH 16 hrs years "	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1935 , to Jan. 14 , 19 50 , that I last saw the deceased alive on Jan. 14 , 19 50 , and that death occurred at 11 p. m. , from the causes and on the date stated above.							
23a. SIGNATURE Lorellyn Sale		(Degree or title) m. D.		23b. ADDRESS 4500 Olive - St. Louis 8		23c. DATE SIGNED Jan. 15, 50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/16/50		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth		24d. LOCATION (City, town, or county) (State) University City, Mo.	
DATE REC'D BY LOCAL REG. JAN 16 1950		REGISTRAR'S SIGNATURE [Signature]		FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson			

(Licensed Embalmer's Statement on Reverse Side)

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed _____

Quero Juding

Licensed Embalmer No. _____

4559

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.